



CLERMONT  
CARDIOLOGY

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## RESPONSIBILITY FOR PAYMENT

Date of appointment: \_\_\_\_\_ Time of appointment: \_\_\_\_\_

I, \_\_\_\_\_, acknowledge that I have scheduled an appointment for a nuclear stress test at Clermont Cardiology. If unable to keep this appointment, I will notify Clermont Cardiology at least 24 hours prior to the scheduled appointment time. If I fail to cancel this appointment at least 24 hours prior to the appointment, I will be responsible for the cost of the scanning isotope, which is a perishable medication ordered specifically for my test.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Thank you for your consideration.